

Sunnyside Pediatrics
24 S 1100 E #301
SLC, UT 84102
Phone: 801-521-2640
Fax: 801-363-6407
medrecords@sunnysidepeds.com

AUTHORIZATION TO RELEASE INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT CURRENT ADDRESS: _____

CURRENT PHONE NUMBER: _____

I authorize **SUNNYSIDE PEDIATRICS** to (PLEASE CHECK ONE BOX BELOW):

Release information to:

Receive information from:

PROVIDER/FACILITY: _____

ADDRESS: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED

- | | |
|---|--|
| <input type="checkbox"/> Complete health record | <input type="checkbox"/> Lab/Radiology reports |
| <input type="checkbox"/> Physical Exam | <input type="checkbox"/> Consultation reports |
| <input type="checkbox"/> Immunization records | <input type="checkbox"/> Other _____ |

REASON FOR RELEASE

- | | |
|--|---|
| <input type="checkbox"/> Change of insurance | <input type="checkbox"/> Referral to specialist |
| <input type="checkbox"/> Moved | <input type="checkbox"/> Personal copy |
| <input type="checkbox"/> Over 18 years old | <input type="checkbox"/> Unhappy with practice |

****If needed before 48 hours there will be a \$25.00 rush fee****

Signature of Patient or Legal Guardian

Date

Printed Name

Relationship to Patient